Prescribed Drugs
Methods and Standards for Establishing Payment Rates

Reimbursement to pharmacy providers is based upon agency-determined allowable product cost for covered drugs plus an agency-determined dispensing fee.

The dispensing fee assigned to each pharmacy provider is based upon agency determinations which consider the lesser of the individual pharmacies' average gross margin per prescription as charged to the general public and determined by a usual and customary prescription price survey submitted by the pharmacy, or the fee determined per analysis of the individual pharmacies' cost study report, which is submitted by the pharmacy and reflects the labor and overhead costs required to dispense a single prescription, plus a standard profit factor. The totals from these calculations are reduced by $.26 for the final dispensing fee determination. Limitations on allowable expenses include exclusion of certain expense categories. Additionally, a regression analysis is based on data from a statistically valid sample of the reporting pharmacies. The individual pharmacies' allowable expenses are subject to percentile limitations as determined by an array of participating providers. Individual fee determinations are also subject to reevaluation and adjustment when report data exceeds regression analysis norms by a factor greater than 1.0 standard error of estimation.

Each of the three following types will have a dispensing fee assignment set at the mean fee determined from the pharmacy cost study analysis:

Out-of-state pharmacies which are not located in border cities as defined in the Provider Manual, and do not exceed 100 prescription claims annually;

New pharmacies, with less than six months' history completed prior to the date specified in the cost report;

Acute care institutional pharmacies.

Pharmacy providers who do not submit a usual and customary prescription price survey and a cost study report, when required, are reimbursed at the agency-determined allowable product cost for covered drugs with a zero dispensing fee. Physicians who dispense drugs to Medicaid/MediKan recipients are reimbursed at the agency-determined allowable product cost for covered drugs plus a dispensing fee of $1.00 per prescription.

Prescribed Drugs
Methods and Standards for Establishing Payment Rates

The allowable drug product cost for determining reimbursement is based upon agency determinations which consider the aggregate upper limits of payment as defined in 42 CFR, 447.331 and 332, the State Maximum Allowable Cost (SMAC), or the estimated acquisition cost (EAC) as determined by the state for all drugs covered by the program. The estimated acquisition cost is determined by consideration of a specific drug product's probable source of supply (wholesale or direct purchase), and from the agency-selected pricing compendia's current listed direct price (DP) or average wholesale price (AWP). If the AWP is utilized, 10% is deducted to set the estimated acquisition cost as the reimbursable cost.

In no case shall reimbursement for a prescription exceed the provider usual and customary charges for that prescription. Where payment to a provider is limited as a result of the usual and customary charge, such reduction shall first be made to the cost of drugs dispensed.

Reimbursement to pharmacy providers for medication supplied through unit-dose or unit-of-use medication delivery systems to program recipients that reside in adult care home facilities shall be for the agency-determined allowable product cost for the quantity of covered drugs needed for 30 days, plus the agency-determined dispensing fee.

KANSAS MEDICAID STATE PLAN

Attachment 4.19B 12b

Methods and Standards for Establishing Payment Rates

#12b Dentures

Dentures are reimbursed on the basis of reasonable fees as related to Medicaid customary charges except no fee is reimbursed in excess of a range maximum. The range of charges provides the base for computation of range maximums.

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KANSAS MEDICAID STATE PLAN

Attachment 4.19B

12c

Methods and Standards for Establishing Payment Rates

#12c Prosthetic Devices

Prosthetic and orthotic devices are reimbursed on the basis of reasonable fees as related to Medicaid customary charges, except no fee is reimbursed in excess of a range maximum. The range of charges provides the base for computation of range maximums.

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KANSAS MEDICAID STATE PLAN

Attachment 4.19B 12d

Methods and Standards for Establishing Payment Rates

#12d Eyeglasses

Eyeglasses are reimbursed on the basis of reasonable fees as related to Medicaid customary charges except no fee is reimbursed in excess of a Statewide maximum. Provider representatives are consulted in reviewing the maximum rate.

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9-28-83
11-22-83

Substitute per letter dated 5/9/97

KANSAS MEDICAID STATE PLAN

Rehabilitation Services
Methods and Standards for Establishing Payment Rates

A. Community Mental Health Centers Services

For community mental health services, including targeted case management, reasonable fees related to customary charges shall be paid except no fee will be paid in excess of the range maximum. The range of charges provides the base for computations.

B. Behavior Management Services

For behavior management services, reasonable fees related to customary charges shall be paid except no fee will be paid in excess of the range maximum. The range of charges provides the base for computations. An amount equal to the prorated monthly SSI amount for an individual will be used to determine the maintenance costs for consumers in Residential Group Treatment. Maintenance costs for Residential Group Treatment are not reimbursable.

For providers of Family Preservation services, Adoption Support services and Foster Care services, payments are based on a bundled case rate. These providers have negotiated and signed contracts with the Department of Social and Rehabilitation Services. The amount to be charged against Medicaid is determined as follows:

1. Encounter data is collected for each service provided.

2. Medicaid eligibility for the referred individual, the provider and the service shall be determined. Where all three criteria are met, the Medicaid fee for service payment rate is multiplied times the number of services provided to determine an allowable Medicaid cost.

3. The amounts determined above are totaled for each eligible Medicaid individual.

4. The amount paid to the provider is totaled for each eligible Medicaid individual.

KANSAS MEDICAID STATE PLAN

B. Behavior Management Services (cont.)

5. The lesser of the amounts determined in steps 3. and 4. is the amount chargeable to federal financial participation for each eligible Medicaid individual.

6. The amount determined in step 5. above is accumulated for all eligible Medicaid individuals.

The net effect of this computation is that federal financial participation is charged no more than the fee for service rates already in effect for the same eligible individuals and existing Medicaid eligible services given the actual usage of services.

All charges for federal financial participation are based on actual encounter data and the steps shown above.

C. Alcohol and Drug Abuse Treatment Services

1. Alcohol and drug abuse treatment services provided by general hospitals are limited to acute detoxification. Reimbursement for that service is according to the Diagnosis Related Group reimbursement system pursuant to the attachment 4.19-A of this Plan.

2. Alcohol and drug abuse treatment services provided by community based residential and day treatment providers will be reimbursed according to the rate set by the Secretary for each service described in Attachment 3.1-A, #13.d of this Plan.

D. Local Education Services

Kan Be Healthy Screening (EPSDT)

For local education agency services, reasonable fees as related to customary charges shall be paid except no fee will be paid in excess of the range maximum. The range of charges provides the base for computations.

Substitute per letter dated 3-12-98 *

KANSAS MEDICAID STATE PLAN

D. Local Education Services (cont.)

Rehabilitation Services

For local education agency services, payment for rehabilitation services will be made on a monthly blended rate basis. This methodology uses a single monthly payment rate to reimburse districts and cooperatives for the full range of medically necessary medical services authorized as part of an Individualized Education Program (IEP). The blended rates were developed for groupings of children identified by their primary disability diagnosis established in the IEP process. The grouping of children by disability diagnosis was used to reflect the similarities in treatment plans and costs for children with the same type of disability.

The blended rate setting methodology is similar to the payment practices used in hospital Diagnosis Related Grouping (DRG) payment systems. This methodology uses actual cost and historical utilization factors to develop a global fee to reimburse providers for the medically necessary services used to treat the child with the diagnosed disability. The blended rate method establishes a fixed individual monthly fee based on the diagnosed disability. In other words, the same monthly diagnosis based payment will be made for each similarly diagnosed individual, based on the historical costs and units of service to be consumed. Appropriate rate setting practices and statistical probability will ensure that, over time, appropriate financial reimbursement will be made for each diagnosis class member. Reimbursement levels will be reviewed annually to determine if inflationary adjustments are necessary.

E. Long-Term Head Injury Rehabilitation Facility Services

For long-term head injury rehabilitation services provided in a Head Injury Rehabilitation Facility, reimbursement shall be based upon a negotiated daily rate amount pursuant to a contract with each provider.

KANSAS MEDICAID STATE PLAN

Attachment 4.19B

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Methods and Standards for Establishing Payment Rates

#14b Services for Individuals Age 65 or Older in Institutions for Mental Diseases

(1) Inpatient Hospital - See Attachment 4.19-A

(2) Intermediate Care Faciltiy - See Attachment 4.19-D

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KANSAS MEDICAID STATE PLAN

Attachment 4.19B 15

Methods and Standards for Establishing Payment Rates

#15 Intermediate Care Facility Services

See Attachment 4.19-D

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